

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
001	Denied. Care beyond first 20 visits or 60 days requires authorization.
002	Denied. Report of accident payable once per claim. Previous payment has been made.
003	Initial office visit payable one time only same claim/provider/diagnosis.
004	Denied. Physical therapy by the attending doctor is limited to 6 treatments.
005	Denied. Physical therapy beyond the first 12 treatments requires authorization.
006	Rental has extended over 30 days. Only short term rental is allowed.
007	Denied. Facet joint injections are limited to four per patient.
008	Denied. Chemonucleolysis is allowed once in a lifetime only.
009	Maximum 2 service units allowed.
010	Maximum 40 hours payable per vocational referral.
011	Maximum 50 hours payable per vocational referral.
012	Maximum 2 hours allowed per vocational referral.
013	Quality or level of service does not meet the Department's standards.
014	Maximum 1 service unit allowed for same day/diagnosis.
015	Maximum of 2 hours travel wait time allowed.
016	Thank you. Your effort to complete this bill correctly has been appreciated.
017	Denied. Meal receipts must be business-stamped or be accompanied by cash register receipt.
018	Additional views/units are not payable on MRI's.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
019	Amount paid is according to hours lost from work per the daily compensation rate.
020	This service is payable only once and must be billed as one line item and one unit of service.
021	Denied. Free parking available at this facility.
022	Consultations not payable to attending physician.
023	Denied. Submit bill to party who requested testimony (e.g. attorney general office, BIIA, etc.)
024	Maximum of 1 hour allowable only.
025	Accumulated services have exceeded the Department limit.
026	This is an individual interim payment.
027	Denied. Not authorized to provide work hardening services. Contact Karen Jost (360)902-5622.
028	A maximum of 1 service unit is allowed.
029	Denied.Home nursing travel, holidays, overtime & weekends are considered the providers overhead
030	A maximum of 300 miles is allowed.
031	This was paid at the highest allowable fee for breakfast, lunch or dinner.
032	Denied. The tooth number billed has not been authorized.
033	Lack of correct amount of units on bill can reduce or delay payment.
034	Number of hours paid per agreement with Departments nursing care consultant.
035	Paid professional component only. Technical component billed by and paid to another provider.
036	Adjustment/deduction taken to credit base anesthesia units that were billed by you in error.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
037	L&I responsible for payment of this bill. Reimburse payments made by other sources.
038	As of 1/1/93 use modifier -7N for x-rays & lab services in conjunction with an IME.
039	Denied. The legal maximum of \$4000 for retraining has been expended.
040	Denied. Resubmit with valid place-of-service code.
041	Adjustment made to this bill per contractual agreement with UR vendor.
042	Payment of this service has been made per Board of Industrial Insurance Appeals.
043	Denied. Procedure code missing from bill.
044	Denied. Out-of-state travel expenses incurred prior to 7-1-91 are not payable.
045	Denied. Type service/procedure code is invalid. Refer to current Fee Schedule for valid code.
046	Payment made to correct your account for the refund which you made to the Department.
047	Denied. Travel to the nearest available treatment is less than 10 miles one way - not payable.
048	Adjudicated per instructions from claims manager.
049	Denied. No report of accident has been received for this claim number by the department.
050	Only one new patient visit allowed within three years.
051	Payment made to EBP for review of service for which claim was not received/initiated by dept.
052	Denied. The maximum allowable number of units was paid on another line or bill.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
053	Srvcs 9/98 through 6/99, 40 maximum units allowed. Srvcs 7/99 on, 32 maximum units allowed.
054	Denied. Clinic account ID may not be used in provider field only payee field.
055	Payment adjusted or denied. Only one unit of service payable per claim.
056	Denied. Chart notes are required for service billed. No additional amount is payable.
057	Submit charges for rehab DRG 462 under your facility's separate rehab unit provider account id.
058	Denied. E/M code not payable with MPE or impairment rating by same provider/claim/date of svc.
059	Payment adjusted to number of service units authorized by the claims manager.
060	Denied. Please rebill using the correct provider number for these services.
061	Allowed at combined procedure code rate per the department's published fee schedule.
062	Fee for visit includes care of the day.
063	Denied. Reopening application is payable only on claims closed over 60 days.
064	Denied. Fee for service includes office call.
065	Only one adjustment form should be submitted listing all changes requested to an ICN bill.
066	Denied. The admit and discharge dates are the same. Rebill this service as outpatient service.
067	Adjusted. Examination completed within six weeks of a "no show" exam billed to the Department.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
069	Denied. The provider is not an approved chiropractic consultant with the department
070	Allowable fee set by Department Chiropractic Consultant based upon review of report.
071	Denied. Injury occurred while in course of employment subject to Longshore & Harbor Workers Act
072	Denied. Rebill services under the performing provider's name and provider number.
073	Payment adjusted per review by Department Nursing Consultant.
074	Denied. Replacement and repair of this item is not covered by the Department.
075	Denied. Requested records not rec'd by August(AHS). Injured worker is not to be billed.
076	Denied. Claim reopened for provisional time loss only. If/when reopened for medical, re-bill.
077	Procedure billed needs a referral id on your bill. To get it, contact referring voc provider.
078	Services paid. Claim now closed and no additional benefits are payable.
079	Denied. This is a rebill of an original that is currently under review by UR contractor.
080	Anesthesia services reimbursed under RBRVS are not paid by base and time units.
081	Units adjusted to 24. This procedure's unit value is calculated on a per hour basis.
082	The modifier used requires a report. No report has been received for these services.
083	When using a group no., you must also indicate by provider number which doctor performed svcs.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
084	Units or payment adjusted to pay maximum allowable amount per day.
085	Units per injury per time period exceeded. Denied/adjusted per current fee schedule maximum.
086	Payment adjusted. Payment of guest convenience items are the injured worker's responsibility.
087	Units adjusted to correct amount. Only 2 additional visits allowed per day.
088	Referring provider id is missing/not valid for this claim. Get id from referring voc provider.
089	Denied. Service dates not within authorized dates for billed referral id.
090	Denied. Travel only reimbursed for scheduled treatment, exams and vocational services.
091	Bill's referral id is missing or invalid. Correct and rebill.
092	Denied. Performing provider id not valid for this date of service.
093	This bill was adjusted in error in 12-90 when the Dept processed accomodation code adjustments.
094	Adjustment made to this bill per contractual agreement with UR vendor.
095	Payment made to UR vendor for review of service for which claim was not received/initiated by dept.
096	Denied. Requested records not rec'd by UR vendor. Injured worker is not to be billed.
097	Denied. This is a rebill of an original that is currently under review by UR vendor.
098	Denied. Incorrect procedure code for referral id/type billed.
099	Charge/fee converted to rate of exchange in effect for date of service.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
100	Effective 9/1/93 Department will not pay for Stadol Nasal Solution.
101	Denied as duplicate. If not a duplicate, submit an adjustment request with documentation.
102	Denied. No VRC is assigned to this referral.
103	Denied. Payee provider is not assigned to this referral id.
104	Denied. Service is included in flat fee or follow up care period for major surgery performed.
105	Denied. Procedure code is incompatible with diagnosis code on the bill.
106	Denied. The therapeutic class and the diagnosis on the bill are incompatible.
107	Board charges are allowed for payment of food items only. Other items are not authorized.
108	Payment of this service has been authorized as a retraining expense.
109	Deduction taken to reimburse the Department for unauthorized or excess payment of this service.
110	Paid technical component only. Professional component billed by and paid to another provider.
111	The procedure modifier(s) required for the surgery(s) on this bill is either invalid or missing
112	Units of service adjusted to comply with the maximum 40 hours payable for this service.
113	When billing "unlisted procedure" code specific description of service must be on the bill.
114	Paid. Condition not accepted but retarding recovery from accepted conditon.
115	Units of service for accomodations conflict with the covered dates listed on your bill.
116	No payment made for this surgical service. It is included in flat fee

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	for major surgery billed.
117	The procedure modifier code is either completely invalid or invalid for the service dates billed.
118	This service has already been billed by and paid to another provider.
119	Paid on adjunctive treatment basis only. Condition not accepted.
120	Denied. The date of service is required. Submit bill only when service has been completed.
121	Not paid. Provider name and/or number is missing or invalid.
122	History adjustment due to consolidation of claim numbers.
123	Denied. This service is not payable in advance.
124	Denied. The beginning/ending service date is missing or invalid.
125	Denied. Bill was received in the Department after 90 days from date of service.
126	Payment processed. Future vouchers for travel over 90 days old will be denied.
127	Denied. The prescription was not written by the recognized attending physician of record.
128	Denied. The prescription was written for a condition unrelated to the industrial injury.
129	Missing or invalid modifier code was billed. Please note corrected code used in this instance.
130	Claimant name was missing from the billing received in the Department.
131	Denied. The prescribing provider number is missing or invalid.
132	Please list all applicable modifiers in the description field when billing modifier 99.
133	Denied. Gasoline and/or automotive costs are included in the mileage

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	reimbursement rate.
134	Allowed at rate established by Washington Administrative Code effective this service date.
135	Parking receipts were not attached to your billing. Payment is allowable at basic rate only.
136	Extra views must be billed under -22 modifier per Fee Schedule/WAC 296-23-01005.
137	Procedure code states "minimum of ___ views." Additional amount not payable for extra views.
138	Payment for report not allowed when procedure code billed requires submission of report.
139	Adjustment processed as result of provider audit.
140	Refund made as result of provider audit.
141	Base units paid only. Actual anesthesia time must be on bill. Submit adjustment to this bill.
142	Allowable fee set by Department Medical Consultant based upon review of report.
143	Provider number corrected to match name. Bill with correct number for provider name in future.
144	The prescription written date is missing or is invalid.
145	Type of service code is missing or is invalid.
146	Denied. The claimant's sex code on this bill is missing or invalid.
147	The daily room rate was missing from the billing you submitted to the Department.
148	The revenue code for this service was missing from the billing you submitted to the Department.
149	Use of this procedure code for this date of service is invalid.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
150	Denied. Claimant date of birth is missing or invalid.
151	The side of body code is invalid. It must be L (left), R (right) B (both) or remain blank.
152	NDC code and/or the prescription number is missing or invalid.
153	Denied. Principal ICD-9 diagnosis code is invalid.
154	Denied. Second ICD-9 diagnosis code is invalid.
155	Drug quantity missing/invalid. If equipment rebill on Statement for Miscellaneous Services.
156	Days supply missing/invalid. If equipment send bill on Statement for Miscellaneous Services.
157	Not responsible for repair or replacement of contacts or glasses not worn at time of injury.
158	Bill paid. You must reimburse the employer the total amount he/she paid for this service.
159	Prescribing physician number on your bill was terminated when the prescription was written.
160	Reduced to office call fee for 90030 or ER visit 90350 per our Medical Aid Rules.
161	Denied. Third ICD-9 diagnosis code is invalid.
162	Denied. Fourth ICD-9 diagnosis code is invalid.
163	Not paid. Diagnosis code missing.
164	Denied. Fifth ICD-9 diagnosis code is invalid.
165	Unable to determine referring physician's name and/or number.
166	Section of the bill indicating if the old glasses prescription was available was not completed.
167	Denied. Patient status code is missing/invalid. Valid codes are 01 through 07, 20, and 30.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
168	Denied. Refraction is not paid when the old prescription is available.
169	Denied. Admitting/principal ICD-9 diagnosis code is not sufficiently specific.
170	Denied. Second ICD-9 diagnosis code is not sufficiently specific.
171	Denied. Third ICD-9 diagnosis code is not sufficiently specific.
172	Type service/procedure code is missing or is an invalid Department CPT procedure code.
173	Denied. The admission date and the service dates are incompatible.
174	Denied. The Department did not authorize these services by this provider for this claim.
175	Service prior to April 1, 1986 must be billed as a separate line item.
176	Denied. Fourth ICD-9 diagnosis code is not sufficiently specific.
177	Denied. Fifth ICD-9 diagnosis code is not sufficiently specific.
178	Denied. First diagnosis code denotes a non-industrial condition or is not sufficiently specific
179	Admit type is invalid. Valid admit types are 1,2,3, and 4.
180	Denied. Principal procedure date is more than 2 days prior to the bill's first covered date.
181	Denied. Principal diagnosis denotes a non-industrial condition or is not sufficiently specific.
182	Incorrect revenue code billed for this service.
183	The units of service are missing or invalid.
184	Charge is missing(do not bill no charge service) or invalid(rate X days isn't equal to charge).
185	The admission date is missing.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
186	Denied. The provider has already been paid for this service under his individual L&I account.
187	Denied. The clinic has already been paid for this service under the clinic's L&I account no.
188	Denied. Second diagnosis denotes a non-industrial condition or is not sufficiently specific.
189	Denied. Third diagnosis denotes a non-industrial condition or is not sufficiently specific.
190	Denied. fourth diagnosis denotes a non-industrial condition or is not sufficiently specific.
191	Denied. Fifth diagnosis denotes a non-industrial condition or is not sufficiently specific.
192	Denied. Resubmit with list of ingredients, their cost & compounding time on form 245-010-000.
193	Denied. The principal ICD-9 diagnosis code is missing.
194	Denied. Authorization of this service has been denied in this claim.
195	Denied. Principal diagnosis has not been accepted as related to this injury.
196	Denied. Second diagnosis has not been accepted as related to this injury.
197	More specific revenue code needed. Use revenue code 291 for purchase or 292 for rental.
198	Denied. The date of surgery and/or surgical procedure code is missing. Send adjustment request.
199	Denied. One or more diagnosis codes in the second through fifth fields are invalid.
200	Denied. Principal and second diagnosis codes not accepted as related to this injury.
201	Department is processing these services under new ICN.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
202	Submission of charges on HCFA 1500 will expedite processing.
203	Charges adjusted according to your state's fee schedule.
204	Denied. Primary and/or secondary diagnoses not accepted as related to this injury.
205	Denied. Bills for crime victim claims must be submitted on paper to the Crime Victims Division.
206	Denied. We have no record of a claim having been filed with the Dept. with this claim number.
207	Denied. Each provider must bill charges separately.
208	Please note the prescribing physician's new number and use it on future bills.
209	This provider is not authorized to provide this service.
210	This transaction is a transfer of the credit portion of the interim payment.
211	Injured worker paid at Dept. rate. Please reimburse the provider for this service.
212	Denied. This is a self-insured claim number.
213	Inpatient bill adjusted to augment DRG database.
214	Denied. The CPT procedure code submitted is not a valid code from the outpatient fee schedule.
215	Submit w/valid revenue code or if service is for lab, radiology, or PT use CPT procedure code.
216	NDC invalid for service date billed.
217	The revenue/procedure code was missing from the bill.
218	Interest penalty as a result of overpayment.
219	Denied. This procedure is considered non-standard and is not payable

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	by the Department.
220	Denied. Bill not submitted in timely manner. Patient is not responsible for this charge.
221	Denied. Only one office call per day is permitted after the first three days of treatment.
222	Denied. Effective January 1, 1987, \$.36 tape billing fee is no longer payable by the Department
223	This history credit reflects a warrant cancellation.
224	The procedure code modifier is not valid in conjunction with the procedure code billed.
225	Denied. The non-covered line item charge exceeds the line item billed charge.
226	Denied. Bill type invalid for this provider type. Correct bill type/provider number & resubmit.
227	Paid as one hour. Supply time span for psychiatric exam in remarks on future bills.
228	Adjusted. On future bills indicate in remarks if psychiatrist was panel member and # of hours.
229	When billing unlisted procedure code, specific description of service must be in remarks.
230	This item must be billed by NDC on the Statement for Pharmacy Services bill form.
231	When billing -22 modifier, you must explain the nature of the additional services in remarks.
232	You must list all applicable modifiers in remarks when billing modifier - 99.
233	The diagnosis supplied on your bill has been denied under this claim number.
234	Paid at non-Washington percent of allowed charge per WAC 296-23A-

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	0230.
235	Denied. Primary and/or secondary diagnosis has been denied under this claim number.
236	Bill remarks do not pertain to bill payment and have delayed processing.
237	Remarks do not justify -22 modifier. Submit paper adjustment with justification.
238	Inpatient admission not medically necessary per Department Medical Consultant. PD at 50 percent
239	Prior authorization not obtained for inpatient admission. Paid at half of allowable fee.
240	Time lost from work is payable only when an examination is requested by the Department.
241	Not payable when injured worker is receiving time loss compensation or has been kept on salary.
242	Bill contains multiple charges for dates when claim was not open. Delete services and rebill.
243	Denied. Please submit a paper bill to James L. Groves Company, Seattle.
244	Denied. Claimant is not eligible under this claim for this date(s) of service.
245	Denied. Please rebill these services on an outpatient bill.
246	Denied. Procedure and/or modifier code is incorrect for service described on bill.
247	When multiple modifiers apply, use 99 & list all applicable modifiers in the description field.
248	Allowed charges reduced to office call. Report billed and paid under 99080.
249	Reimbursed at rate of exchange in effect at the time of service.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
250	Denied to Department due to total lack of identifying information as to provider of services.
251	Procedure code 72140 is invalid, use codes 72141 through 72144 to bill for spinal MRI's.
252	Claim closed. Only services requested by the Department are payable.
253	Use revenue codes 430 through 439 to bill occupational therapy. Do not bill with CPT codes.
254	Patient status code "30" invalid for DRG bill; correct and resubmit or submit final bill only.
255	Condition code is invalid. Must be blank or 61 for high cost outlier request. Correct & resubmit
256	Claim now closed.
257	Principal diagnosis code unacceptable according to Medicare Code Editor. Correct and resubmit.
258	Credit taken to offset previous payment made by gross adjustment.
259	Denied. Claim ID/claimant name mismatch. Call 1-800-848-0811 to confirm claim ID b4 rebilling.
260	Service was for concurrent treatment which has not been authorized for this injury.
261	Generically priced. Prescribing doctor hasn't submitted justification to issue brand name drug.
262	ICD-9 procedure code(s) invalid. Correct and resubmit.
263	Denied. Duplicate claim number. Contact the Department's local office for the correct number.
264	Accident claim not yet allowed. Bill held pending claim allowance. Do not rebill.
265	Denied. Service rendered after date of pension and no treatment order has been authorized.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
266	Per contract- "Free" trial of transcutaneous nerve stimulator.
267	Denied. This is a medical contract claim. Submit your bill to the employer contract carrier.
268	Denied. Travel expense must be billed to the Department within 12 months of the date of travel.
269	All ICD-9 operating room procedure codes are non-specific. Correct and resubmit.
270	Claimant's age invalid for diagnosis. Correct and resubmit.
271	Denied. Sum of line item charges does not equal total billed charge. Correct and resubmit.
272	Please note - when billing this procedure code enter 001 in bill's units of service field.
273	Please note the provider number. Use this number to bill for psychiatric unit services.
274	Please note the provider number. Use this number to bill for alcohol unit service.
275	Denied as duplicate. The service(s) were paid under your previous provider account number.
276	Denied. The diagnosis listed on your billing has not been accepted as related to this injury.
277	Denied. Authorization of this procedure, drug or service has been denied under this claim number
278	Denied. Department notification of cancellation was provided within three days of examination.
279	Deduction taken for bills previously paid on a claim which has subsequently been rejected.
280	Denied. Claim ID billed is not active. Call 1-800-831-5227 to confirm the ID before rebilling.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
281	Denied. The date of service is prior to the date of injury.
282	Your bill must be held pending adjudication of this claim.
283	Bills do not exceed department high cost outlier thresholds.
284	DRG cannot be assigned. Check age, sex, patient status, procedure & diagnosis codes & resubmit.
285	Not referred by the attending physician of record and Department authorization not obtained.
286	Denied. The CPT code for the surgical procedure performed must be listed on the billing.
287	Denied. Submitter not authorized to submit bills for this provider.
288	Bill returned to provider with new provider application form. Previous app was not returned.
289	Please note the provider number. Use this number to bill for rehabilitation unit services.
290	Denied. Include outpatient charges on the inpatient bill to be resubmitted to the Department.
291	Denied. Explanation of -52 modifier not supplied as per contract requirements. Rebill.
292	Denied. Our records do not show the "provider" and "group" account numbers on bill as related.
293	Denied. These services were not billed in accordance with contract. Rebill per contract terms.
294	Denied. Dates of service must be itemized. Correct and resubmit.
295	Claimant reimbursement bill returned to claimant due to invalid claim number.
296	Claimant reimbursement-denied to Dept due to invalid claim # and no claimant address on bill.
297	Denied. Dental procedure code is missing or is not a valid 1987

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	Americandental Assoc code.
298	This payment is due to the hospital discount applied to your audit refund.
299	Denied. As of July 1990, this revenue code is not a valid Washington State code.
300	Services deleted were rendered after or during period of claim closure.
301	Denied. The bill submitted was illegible. Information must be clearly printed and accurate.
302	Unable to process. Submit paper bill directly to the Department on the appropriate bill form.
303	Denied. This claim has been suspended and no benefits are payable during suspended time period.
304	Denied. This service is not authorized.
305	This transaction has been taken to correct the file per a special request.
306	Current charges are being processed. Submit an itemized billing for the balance forward amounts
307	Corrections to this bill (ICN) have been made per your request.
308	Denied. This service is not an authorized vocational expense.
309	Charges previously paid for this date. If this is not a duplicate submit adjustment to old bill
310	Denied. Service was before or after the dates authorized for the pain clinic program.
311	Denied. A pain program has not been authorized for this claimant.
312	This transaction cancels interim payment credit balance in this provider account.
313	This transaction reflects interim payment credit balance refund and

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	corrects year to date info.
314	This transaction reduces the interim payment credit balance in this provider account.
315	This travel related expense is denied in accordance with Department policy.
316	This is a history adjustment to correct an error in firm number and class.
317	Denied. The diagnosis code denotes a non-industrial condition or is not sufficiently specific.
318	Denied. Office visit includes manipulation.
319	Revenue code invalid for this type of hospital service (in-patient vs out-patient). Rebill.
320	Note claim number and your provider number. These are required on all bills sent to the Dept.
321	Revenue code(s) invalid for date(s) of service billed. Rebill with correct codes.
322	Denied. Service is in violation of specific restrictions imposed by the Dept of Licensing.
323	This procedure code wasn't valid at time of service. Refer to the latest Fee Schedule revision.
324	Denied. Bill and reports indicate services were provided for a new injury/incident.
325	An adjusted bill paid without deducting the original bill. This is a corrective action.
326	Denied. This service or drug is not allowed for treatment of industrial injuries.
327	Denied. No report received from the attending doctor to justify authorization of this service.
328	Denied. Claimant age and/or sex invalid for this procedure or

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	diagnosis.
329	This adjustment is the result of an independent audit of charges for the service(s).
330	Denied. This procedure was not included as a part of the approved program for this provider.
331	Please refer to the billing instructions provided by Labor and Industries.
332	Denied. The type of service and/or procedure is not authorized for this provider type.
333	Do not bill several procedures/diagnoses/dates in one line. These will be denied in the future.
334	These services were not medically necessary.
335	Please note the payee number. You must use this number when billing for pain clinic services.
336	Provider number and/or name used were incorrect. Note correction(s) and use on future billings.
337	This is a repayment. You submitted a refund for services which we are unable to identify.
338	This is a repayment. You submitted a refund in excess of what was required.
339	Bill returned to provider with application required to establish provider account.
340	Denied. Submit bill on original Department approved form. Photocopies cannot be processed.
341	Side of body code is required for this diagnosis.
342	This diagnosis is not acceptable. The Department requires use of a more specific ICD-9.
343	Denied. Interpreters must have prior authorization and bill the Department directly.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
344	Denied. The ICD-9 diagnosis code is missing or invalid.
345	Denied.Special exam and/or Dept investigation relating this condition to the injury is pending.
346	Full DRG payment for inpatient stay made on this ICN.
347	Denied. Rebill therapy on outpatient bill. Submit other charges as adjustment to inpatient bill
348	Please note the provider number. Use it on the current bill forms submitted for hospital svcs.
349	Denied. This service is not payable in addition to code 90670, 90675, 90676 or 90677.
350	Report is required when this procedure and/or modifier code is billed. No report was received.
351	Denied. Incorrect revenue code used for the described service billed.
352	This ICN paid at \$0.00. Full DRG payment for this inpatient stay made on separate ICN.
353	Denied. Code must be authorized before payment can be made. Call 800-848-0811 for authorization.
354	Denied. Bill detail is incomplete, invalid or missing.
355	The tooth number on your billing is invalid. It must be in the range 01 through 32.
356	The tooth number is required for this procedure and was not on your submitted billing.
357	Payment processed. Future medical travel requires prior approval. Contact your claims manager.
358	Services provided are not greater than those usually required for the listed procedure.
359	These services are generally provided as an adjunct to common medical services.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
360	Circumstances do not clearly warrant additional charge beyond usual charge for basic service.
361	Calls and/or conferences with claimant's attorney are not necessary medical services.
362	Denied. The distance traveled does not justify payment of this meal.
363	Payment of service(s) made at the Department's maximum allowable rate(s).
364	Payment made for the actual cost of service indicated on the receipt(s) attached to your bill.
365	Denied. This place of service is not authorized for this procedure.
366	Denied. The provider speciality on the Department record does not include this service.
367	The revenue code billed is invalid.
368	The charges for pain program services have been allowed as billed.
369	Transport/professional services-rebill HCFA 1500. Others-invalid or not authorized for workers.
370	Adjudicated per agreement/contract.
371	Denied. Service must be billed as office call, which includes treatment of the day.
372	We have received information verifying that the service billed was not performed.
373	Denied. This drug requires pre-authorization. For authorization call 1-800-848-0811.
374	Full flat fee allowed for primary condition/procedure, add'l cond/proc paid at percentage.
375	Allowed as office call which includes care of the day per the Maximum Fee Schedule.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
376	Paid previously to the claimant. It is his/her responsibility to reimburse you for this service
377	Interest not allowed. Criteria for submission and/or bill data has not been met.
378	This bill does not meet the criteria established by the Department for interest payment.
379	This line item is for payment of interest.
380	Payment recouped/denied. Include non-therapy outpatient services on resubmitted inpatient bill.
381	This bill is not payable at this time. The claim is in abeyance pending further determination.
382	Denied. Incremental nursing charge rates must be billed with revenue code 23X.
383	This line item deducted. Include charge on inpatient bill to be resubmitted to Department.
384	Denied. The revenue code billed does not match the description of the services rendered.
385	Denied. Maximum allowed payment has already been made per contract agreement.
386	Payment not made on this bill. This service(s) is duplicated on another bill in process.
387	The original bill was correctly adjudicated/processed; an adjustment to it is not allowable.
388	Additional payment for treatment to contiguous area is not allowed.
389	Procedure code changed to more closely reflect service indicated. Please note for future billing
390	Denied. A report is required when billing for this service or procedure.
391	This is an adjustment to correct a previously adjudicated/processed

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	bill.
392	Payment for this service has been made to the vendor. Contact them for reimbursement.
393	Services in this date span were previously paid. No substantiation for added charges received.
394	Denied. This service is not covered by the Department. Claimant is responsible.
395	Time span for psychiatric exam not supplied on bill. Paid as one hour.
396	Payment delay caused by the use of the same procedure code for overlapping dates of service.
397	These charges have been included for payment and processed on another bill.
398	Denied. Invalid data entered in claim number field.
399	New incident-unrelated to industrial injury. Bill claimant on private, non-industrial basis.
400	There was no notification of this admit. The bill is referred to UR vendor for possible audit.
401	The provider master records indicate this provider number was terminated due to invalid/address
402	Denied. When billing this code, a description must be in remarks or on the bill.
403	Denied. Resubmit bill using your pain clinic provider number.
404	Denied. Provider was terminated or was not enrolled on date of service.
405	Rebill:performing provider name/acct # and group name must be in box 31 or 33 on new bill form.
406	Denied. Provider does not have a valid, active license.
407	Bill not payable at this time/reopening is in provisional status pending

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	further determination.
408	Payment made for treatment of allowed condition(s) only. Bill claimant for noncovered treatment
409	Compounded prescription only paid. Rebill non-NDC items on "Statement for Misc Services".
410	Billed charge changed to reflect the amount billable per current travel expense increases.
411	Rejection of this claim has been overturned. Claim has now been allowed by the Department.
412	Claim is in appeal process before the board. Please rebill services after change in claim status
413	Denied. Professional interpret of this service payable only if test done in inpatient setting.
414	Repayment due to audit decision that has been reversed by the department.
415	Bill has been paid by A-19. Questions concerning this transaction should contact deduct desk.
416	Denied. This reopening app. has been billed by and paid to the attending physician of record.
417	Denied. These services need to be rebilled under the appropriate claim number.
418	Payment made to correct your account for the duplicate refund submitted to the department.
419	There were no duplicate payments. You were posting from a credit balance remittance advice.
420	Deduction taken. Treatment rendered after 30 visit maximum.
421	Please refer to the notification of potential DRG sent in regard to this bill.
422	Denied. Only procedures 99080, 99083 and 99084 are payable under

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	this provider number.
423	Lack of the provider number will result in delayed payment and/or return of your bills.
424	Denied. Compensation not payable when the time loss from work was less than four hours.
425	Note the correction to this ICD9 diagnosis code. The code was incorrectly billed.
426	Denied. This code is not payable in combination with codes 97530 or 97531.
427	Bill suspended. Submitter not authorized to submit bills for this provider. Call 360-902-6511
428	Outpatient service within 24 hrs of an admit paid by DRG method is considered already paid.
429	Denied. Services requested by the claimant's attorney must be billed to the attorney.
430	Denied. Consult code not payable to physician providing ongoing care.
431	Autopsy bill with no claim #. Refer to service date & first 2 letters of last name to identify.
432	50% of allowable charges paid. Bill balance to employer under self insured claim number.
433	Denied. If service rendered was a rating exam, rebill with procedure code 1106M.
434	Denied. Tax not payable when related charges are denied.
435	Maximum allowable fee for this service has been paid. Payment for this line item is reduced.
436	Prior authorization number on bill invalid for this claim and/or admit.
437	Denied per WAC 296-20-03001, no more than 6 injections will be authorized per patient.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
438	Bill paid. Please remove injured worker from collections.
439	Denied. Massage svcs that are part of a treatment plan ordered by a doctor are exempt from tax.
440	Denied. Provider's application to treat injured workers has been denied.
441	Denied. Bills for copies of records must be submitted by the provider performing the service.
442	Denied. Provider was suspended or was not enrolled on date of service.
443	Denied. Claimant paid amount is greater than total charge.
444	Refund made as a result of a penalty imposed on the provider.
445	Denied. Claim ID field has blanks and/or invalid data. Call 1-800-848-0811 to confirm claim ID.
446	Denied. This bill was in the bill suspense file for over 2 years and has become outdated.
447	Denied. This supply/service is "bundled" into another procedure.
448	Base code paid within endoscopic family code.
449	Denied. No retraining bills are payable during a plan interrupt.
450	Denied. The admittance date is not within the date span for the billed notification (PA) number
451	Denied. The 10-digit prior authorization ID is for an admission denied by L&I Claims Manager.
452	Denied. The notification (PA) number on the bill is not a valid number for this claim.
453	Denied. The Department has not received the required documentation for this admission.
454	For admit dates of July 18, 1988 and after include the prior authorization number in field 91.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
455	Outpatient service within 24 hrs of an admit must be billed as inpatient on the inpatient bill.
456	This readmission/transfer has been denied as a result of a medical review.
457	Denied. CPT coding was on the bill. Pain clinic service must be billed by revenue code.
458	We have changed the units billed to 1 and paid the procedure at the rate for 1 unit of service.
459	Excessive units of service were billed-enter only 1 unit per times the procedure was performed.
460	Denied. A telephone call to your office verified that errors were made in the charges billed.
461	Denied. Immunization procedures include the cost of materials.
462	Denied. Procedure 97261 is payable only when an additional area of the body is manipulated.
463	Denied. Payment for room accomodation charge for the date of discharge is not payable.
464	Per medical review-the billed discharge status was corrected and payment made accordingly.
465	Please rebill ambulance service on a HCFA form using your professional service provider number.
466	Denied.Please submit request for interest including justification, to MIPS at mail ident.4203
467	Denied. Use code 97201 to bill for added service or time. Submit an adjustment to this bill.
468	Denied. This service is not payable when billed with codes 97124/97125 or 97200/97201.
469	This request for interest payment has been forwarded to our fiscal unit for payment.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
470	Denied. Please resubmit this inpatient bill with the required attachments.
471	Denied. Revenue code needs CPT/HCPCS procedure code for APG assignment-procedure code missing.
472	Denied per your affidavit stating that you were not entitled to payment for this service.
473	Denied. Procedure 99025 payable only in conjunction with starred (*) CPT surgical codes.
474	There was no notification of this admit. The bill is referred to AUGMED for possible audit.
475	Returned. The provider number and the name on the bill do not match.
476	Thank you. Your effort to provide information needed to process this transaction is appreciated
477	Denied. Units of service are invalid. Please rebill with correct unit/hours.
478	Denied. Missed appointment was cancelled 3 or more days prior to the appointment date.
479	POAC retroactively adjusted to conform with July 1, 1993 effective date.Refer to 6/1/93 memo.
480	As of last cut-off date, this bill was on the provider's direct entry suspense file.
481	Denied. Sixth diagnosis code is not sufficiently specific.
482	Denied. Seventh diagnosis code is not sufficiently specific.
483	Denied. Eighth diagnosis code is not sufficiently specific.
484	Denied. Ninth diagnosis code is not sufficiently specific.
485	Denied. Sixth diagnosis denotes a non-industrial condition or is not sufficiently specific.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
486	Denied. Seventh diagnosis denotes a non-industrial condition or is not sufficiently specific.
487	Denied. Eighth diagnosis denotes a non-industrial condition or is not sufficiently specific.
488	Denied. Ninth diagnosis denotes a non-industrial condition or is not sufficiently specific.
489	Denied. Sixth ICD-9 diagnosis code is invalid.
490	Denied. Seventh ICD-9 diagnosis code is invalid.
491	Denied. Eighth ICD-9 diagnosis code is invalid.
492	Denied. Ninth ICD-9 diagnosis code is invalid.
493	Denied. Revenue code needs CPT/HCPCS procedure code for APG assignment - procedure code invalid.
497	Employer reimbursed by hand warrant for payment of the bill.
498	An adjustment to this bill is in process and will appear on a future remittance advice.
499	Denied. Procedure previously paid for date(s) of service. Submit adjustment to paid bill.
500	Date(s) of service on this bill have been changed to correspond with the retraining approval.
501	Denied. Service was rendered outside of the authorized time period.
502	Payment made at amount authorized for this retraining procedure code.
503	Denied. The legal maximum of \$3000 for retraining has been expended.
504	Approval of additional funds allows payment of previously denied or reduced bill.
505	Denied. This revenue code is invalid for outpatient service.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
506	Paid at a reduced rate. Procedure not authorized on an inpatient basis.
507	Denied. Retraining plan not approved on this claim.
508	Please bill modifier -27 with any dates of service prior to 9-1-93.
509	Pharmacy submitted claimant reimbursement. Injured worker will be reimbursed for payment.
510	Denied. No balance remains in approved funds for this procedure. Contact vocational counselor.
511	Denied. The Department records do not contain approval of retraining services for this claim.
512	Prescription bill reversal submitted by pharmacy.
513	Prescribing provider not authorized for this claim. Bill not paid.
514	Denied. Drug refill too soon.
515	Accident claim not yet allowed. Point of service bill denied pending claim allowance.
516	Denied. Services not requested.
550	Please read your remittance advice newsletter dated 6-08-93 re: name & number do not match.
555	Tax computation adjusted and paid to reflect payment of 14.1 percent multiplied by CHG billed.
556	Denied. The Department does not accept minus charges.
559	Pending. Do not rebill or adjust. Contact L&I every 60 days for status.
560	Patient's accident rejected by L&I state fund and service not authorized. Contact the patient.
561	Denied. Surgical tray is not payable with the procedure billed.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
562	Avoid possible bill rejection! Please contact your nearest service location for new bill forms.
566	Manually priced due to other surgery bills w/same date. Modifiers are ranked within bill only.
580	Denied. This service payable at intervals of no less than 6 months. See WA RBRVS payment policies.
583	Denied. This is not a managed care pilot claim. Rebill using your fee for service provider #.
589	Codes not payable in combination. Rebill exam with codes in range of 90671-90695 or Z0001-Z0045
598	Pending. Do not rebill or adjust. It will be reflected on a future remittance advice.
599	Pending. Do not rebill or adjust until this bill is paid or denied.
600	Return letter for inpatient hospital bills containing multiple charges for unrelated conditions
601	Return letter for inpatient hospital bills containing multiple charges during a period of claim
602	Return letter for inpatient bills where CPT procedure codes have been used instead of ICD-9.
603	Return letter for returning non-payable bills to unlicensed providers.
604	Return letter for ungrouped CPT codes on hospital bills.
605	Letter to return adjustment requests for hospital bills previously adjusted as a result of an I
606	Return letter (for providers) explaining that L&I is no "co-pay".
607	Return letter for inpatient DRG interim bill.
608	Return letter (for workers) explaining that L&I is not "co-pay".
609	Return letter for invalid inpatient hospital ICD-9 codes.

## Dept. of Labor & Industries Explanation of Benefits

<b>EOB</b>	<b>DESCRIPTION</b>
610	Return letter for problem with principal (first) diagnosis on hospital bill.
611	Return letter for hospital bill with invalid data.
612	Return letter for inpatient hospital bill with invalid age or sex-code data.
613	Return letter for skilled nursing facility charge submitted on a UB92.
614	Return letter for inpatient hospital bills that have invalid data and DRG cannot be assigned.
617	Return letter for possible duplicate bill.
621	Return letter for late charges that must be requested by adjustment to previously paid bill.
622	Return letter for inpatient bill with invalid units of service for room charges.
623	Return letter for IP bill submitted without prior notification and selected for audit
624	Return letter for IP bill regarding admit & discharge dates being equal
625	Letter to return adjustment requests for hospital bills previously adjusted as a result of an...
626	Return letter for inpatient bill with invalid units of service for room charges.
628	Return letter for denied services on Managed Care Claims.
629	Rtn ltr for bills submitted on wrong bill form. Provider instructed to resubmit charges using t
630	Return letter for negative charges billed. Provider instructed to resubmit bill listing only ch
631	Return letter for bill that is not related to a Washington State Worker's Compensation claim.
632	Return letter for compounded prescription billed on wrong bill form.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
633	Return letter for IP bill with incorrect information.
634	Return letter for IP bill for services submitted within 24 hours.
635	Return letter for bill using "old" and "new" IME codes. Provider instructed to resubmit bill us
636	Return letter for IP bill regarding admit & discharge dates being equal.
637	Return letter for IP bill submitted without prior notification and selected for audit.
640	Return letter for IME bill. Another bill for this date of service was previously paid under dif
641	Return letter for bill using out-of-date procedure code for a disability rating or an IME. Prov
645	Return letter for compound drugs billed incorrectly.
650	Return letter for vocational travel expense billings with incomplete or missing information.
651	Return letter for hospital bills that don't have itemized detail.
653	Return letter for bills submitted for which no claim exists in the Department for claimant name
654	Rtn ltr for Misc & HCFA billing which have multiple missing/invalid detail including billing wh
655	Rtn ltr for IH hospital bills which have multiple missing detail including billing which is for
656	Rtn ltr for pharmacy bills which have multiple missing/invalid detail including billing which I
657	Rtn ltr for claimant travel bills which have multiple missing detail including billing which I
658	Rtn ltr for bills received on wrong bill form including billing which is for more than 1 claim

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
659	Rtn ltr for hospital bills which did not have a summary charge sheet of revenue codes with corr
660	Return letter for vocational bills on which too many line items have been included in a bill sp
661	Return letter for bill on claims in abeyance.
662	Rtn ltr for possible dup bills when the previously paid bill was paid for a date range, by summ
663	Return letter for travel vouchers.
664	Return letter for lines that are illegible/unreadable.
665	Return letter to claimant who has requested reimbursement for services which he paid.
666	Return letter for bills with dates of service greater than 12 months old.
667	Return letter to claimant or provider who has requested reimbursement or billed for services on
668	Return letter for claims before the appeals board.
669	Return letter for claims where reopening action is pending.
670	Blank return letter.
671	Return letter for hospital bills whose charges need separation for unrelated conditions.
672	Letter for returning bills for unitemized CPT codes.
673	Return letter for prescription reimbursement to claimant for drug which requires authorization
674	Return letter for claimant reimbursement with charges for services over 12 months old.
675	Return letter for pharmacy bill with charges for services over 12 months old.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
680	Return letter for bill submitted for an injured worker who has employed by Mayr Brothers at the
698	Return letter for bill which includes charges for services rendered during period claim closure.
699	Return letter for bill which includes charges for services rendered over 12 months ago.
700	Interest penalty is the result of an audit.
701	Denied. The amount of hours missed from work are not clear. Please correct and resubmit.
702	Proc billed not allwd in comb w/other code billed for this dos. Refer to current fee schedule.
703	Adjusted. Only 1 unit of service allowed per day. Refer to current fee schedule.
704	Denied. Only 1 unit of service allowed per day. Refer to current fee schedule.
740	Denied. Supplies should be billed using the appropriate revenue code(s).
742	Transferred credit balance from provider number to payee number.
743	Transferred credit balance to payee number from provider number.
744	History only. Paid under correct claim number for this date/nature of injury.
745	Paid under correct provider number for date(s) of service.
746	Patient's accident rejected by L&I state fund and service not authorized. Contact the patient.
747	Balance of job mod costs must be billed to and paid by injured worker's employer.
748	Bill paid, but might be adjusted after receipt of utilization reviewers' post-discharge report.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
800	Only the technical portion of the x-ray is payable during the follow-up by the surgeon.
801	Denied. 908__ not alwd w/E&M visit proc codes. You must use psychotherapy codes instead of E&M.
802	Denied. Procedure code 76140 not payable in conjunction with these services.
803	Denied. These svcs are not payable in conjunction w/modalities and/or treatment for the same day
804	Denied. Time and/or co-signature missing from bill.
805	Denied. Please refer to the HCPCS section of your current Fee Schedule for correct proc. code.
806	Denied. This service is not payable in addition to single examiner exams.
807	Denied the provider specialty on the department record does not include radiology consults.
808	Denied. Revenue code for Medicaid only.
809	Paid at fee schedule max. Mod 22 requires unusual circumstances and supporting documentation.
810	This patient is a participant in the managed care pilot program.
811	Portable/mobile x-rays not payable to hospital based providers.
812	Bill physician assistant with PA name, supervising physician name and physician account number.
813	Denied. Rental fees cannot exceed purchase price.
814	Denied. Lab work is not payable when billed with complex assessment.
815	Denied. Provider is not a department approved Independent Medical Examiner.
816	Denied. Please bill Kaiser/Attn: Kathleen Sharp/2701 NW Vaughn

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	#700/Portland, OR 97210.
817	Free Standing surgical center not payable for this procedure.
818	Denied. Bill the primary occupational medicine managed care provider.
819	Denied. Worker's MCPP participation period has ended. Rebill using fee for svc provider #.
820	Denied. Service included in Pain Clinic fees and not payable separately.
821	Denied. Contact the primary occup. Medicine managed care provider at 1-800-443-0996, ext.0845.
822	Mangd care pilot claim. Only rppt of accdnt, initial ov and dx studies are payable by the dept.
823	Denied.Pharmacological evaluation is not payable with an Evaluation and Mgmnt procedure code.
824	Denied. Managed Care claim, please refer to PB 95-02. Per WAC 296-20-010 do not bill worker.
825	Revenue code 452 not allowed. Use 450 to bill 451/452 combined charges.
826	Procedure not authorized. Call 1 <sup>st</sup> Health/EBP for review: 1-800-541-2894. Rebill when auth'd.
827	Denied. A supplemental medical report (code 1056M) was not requested and/or received.
828	Denied. Maximum of 11 sympathetic blocks have been billed for this claim.
829	Denied. Two procedures w/the same descriptions have been billed, the higher value was paid.
830	Paid per board order or agreement of parties.
831	Denied. The procedure is payable under a different procedure code. Refer to current fee schedule.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
832	Denied. These services are no longer payable and are included in purchase price of hearing aid.
833	Denied. Bill returned w/application. Provider address on file doesn't match address on bill.
834	Please note the prov number. You must use this number when billing for work hardening services.
835	Denied. Additional views, slices or levels of CT scans are not payable.
836	Denied. Outpatient dates of service cannot overlap inpatient stay.
837	Denied. The date of service does not correspond to the supporting document's date of service.
838	Procedure not authorized. Call UR vendor for review: 1-800-541-2894. Rebill when authorized.
839	Denied for audit. UR vendor will be contacting you regarding this bill. Do not rebill.
840	System resource error. Bill not processed. Resubmit.
841	System resource error. (Claimant eligibility). Bill not processed. Resubmit.
842	Denied for audit. EBP Health Plans will be contacting you regarding this bill. Do not rebill.
843	System resource error. (Provider eligibility). Bill not processed. Resubmit.
844	Denied. This must be re-billed on miscellaneous bill form.
845	Denied. NDC obsolete or expired for date Rx filled. Verify correct NDC used. Rebill if necessary.
846	Denied. Prescribing provider provider's number required when generic substitution not allowed.
847	Automated multi-channel test(s) paid at max. allowed for unduplicated tests performed.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
848	Denied. Lab test(s) for service date must all be billed on one ICN. Send adjustment for pd ICN.
849	System cannot determine pricing method. Submit manual bill.
850	In the future, please list the individual provider number as well as the clinic provider number
851	Denied. Payable only if lab test performed on inpatient basis.
852	Denied. Complex fees not payable in conjunction with single examiner examinations.
853	Microfiche handling payable only once per exam assignment.
854	Bill not processed. System error. Submit manual bill.
855	Bill not processed. Provider on review. Submit manual bill.
856	Denied. Surgery CPT previously paid for service date. Add this charge on adjustment to that ICN.
857	Denied. This bill was in direct entry suspense file for over 180 days and has become outdated.
858	System resource error (drug file). Bill not processed. Resubmit.
859	Denied. A warranty is required for all hearing aids. No warranty has been received.
860	Invalid data removed from prior auth field. If no prior auth number required, leave field blank
861	Denied. There is no employer/employee relationship.
862	Denied. Travel not authorized on pension claims with or without a treatment order.
863	Denied. Bill submitted without prior auth. Call UR Vendor 1-800-541-2894. Rebill when authorized.
864	Allowed Amt is \$0.00. Immunobiologic is distributed at no cost by centers for disease control.
865	Denied. Chart notes required for service billed. No chart notes

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	received.
866	Denied. Call UR Vendor 1-800-541-2894 to be reviewed. Rebill when authorized.
867	Decision made by the Office of the Medical Director to pay for non-covered services.
868	Denied. 10-character numeric prior authorization ID required, but is missing from your bill.
869	Item paid. Your -99 modifier was payment & info modifiers. Changed to payment modifier only.
870	Denied. Date of Service on bill does not match the review date or report date.
871	Denied. Submit your bill to Department of Energy (509-376-1416).
872	Eff. DOS 7/1/00 providers must use 00100-01999 to bill for services paid with base & time units.
873	Proc 99080 for narrative rpts only payable every 60 days unless specifically requested by dept.
874	Prior authorization was not obtained. Claim manager has denied.
875	You cannot use your clinic provider number to bill. Please rebill using the correct prov number.
876	Mileage has been reduced. Mileage over 50 miles one-way needs prior approval.
877	Claim closed during part of date span. Call 1-800-831-5227 for claim closure info before rebill.
878	Fluoroscopy must be used when performing this procedure.
879	Denied. Diagnosis/Procedure not authorized on treatment order.
880	Denied. Only 1 unit of service allowed per claim.
881	Denied. Rebill to Dept. of L&I, Self Ins. Attn: Bankrupt Desk, P.O. Box 44892, Oly, WA 985044892

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
882	Denied. Type SVC/Proc code is invalid. Refer to current WA State fee schedule for valid code.
883	Repayment made to provider. Department has already done an adjustment to correct your account.
884	Refund is being returned. Generally accident report, initial visit & necessary tests are payabl
885	ASC service paid at the lesser; 100% fee schedule or billed charge.
886	ASC service paid at the lesser; 50% fee schedule or billed charge.
887	ASC service paid at the lesser; 25% fee schedule or billed charge.
888	Denied. Resubmit bill with required copy of approved pre-job/job modification application form.
889	Denied. ASC procedures for service date must all be billed on one ICN. Send adjustment to PD ICN.
890	Denied. The procedure modifier code is invalid for this provider type.
896	Denied. Repayment to pick up prescriptions/refills is not allowed travel expense.
897	Denied per provider request.
898	Too many exceptions for your bill to process. Break this billing down to 7 line items each bill
899	Too many errors for bill payment. Refer to Fee Schedule/Bill Instruction packet and resubmit.
900	Payment has been made to a payee holding a lien.
901	Payment is received as the result of a lien.
902	Third party recovery made. Payment is the patient's responsibility. Do not rebill L&I.
903	Action is being taken on this bill. Do not make adjustments until this bill is paid or denied.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
904	Repayment of adjustment/deduct on bill(s) which refund/returned L&I warrant was received.
905	Denied. Submit adjustment with copy of invoice showing your cost for drugs/supplies attached.
906	This adjustment is the result of an independent audit of charges for this hospitalization.
907	Flat fee adjusted. After care charges paid to transfer physician.
908	Denied. Service is included in flat fee.
909	Service balance was previously paid in this claim or a related claim for this claimant.
910	Bill adjusted. There was an error in your computation.
911	This service was paid on a diagnostic basis only.
912	Adjusted charge. Unlisted fee set by the Department allowed.
913	Consultation fee paid; treatment fees paid only to the attending physician.
914	Reopening exam and application paid; claim remains closed.
915	Rebill physician professional fees on HCFA 1500 with CPT-4 service codes.
916	Denied. Multiple procedures/diagnoses/dates in a line item cannot be processed. Rebill services
917	Denied. Wrong diagnosis or procedure code used for the described condition or service billed.
918	Report/documentation submitted does not justify the code and/or fee billed.
919	Denied. Multiple claim numbers on one bill cannot be processed. Rebill separately.
920	Denied. The procedure code and/or report indicate the service was

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	for an unrelated condition.
921	Denied. Crime victim claim. Your bill has been forwarded to the Crime Victims Division.
922	Denied. Reopening application not received.
923	Denied. This is a self-insured claim. Submit bill to the employer.
924	Bill paid. You must reimburse the claimant the total amount he/she paid for this service.
925	Adjusted in accordance with the Department's published Fee Schedule.
926	Professional fee adjusted to current Department rate.
927	Balance paid separately under different claim number or different fund.
928	Denied. Attach copy of your receipt to copy of this statement and send to the Department.
929	Denied. Travel less than 10 miles one way is not payable.
930	Denied. Only authorized travel over 10 miles 1 way to nearest available treatment is payable.
931	Medical travel expense not payable when residence is over 50 miles from the Wash. state border.
932	Denied. The distance traveled doesn't justify payment for lodging.
933	Denied. Emergency room report required.
934	As many items as possible have been processed on your bill. Rebill unprocessed services.
935	Denied. This is a duplicate charge.
936	Processed using the injured worker's name the Department has listed for this claim number.
937	You have used the wrong bill form for this service. Bill on proper bill

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
	form in the future.
938	Denied. Justification required for more than one round trip travel on same day.
939	Denied. Rebill or submit copy of remittance advice (circle ICN number). Attach required reports
940	Adjusted. Travel expense allowed to the nearest point of available treatment.
941	Denied. These services were paid by a private insurance carrier whom we have reimbursed directly
942	Denied. Provider is not the attending physician of record. This service is not authorized.
943	Denied. This injection is paid only in hospital setting for treatment of burns or fractures.
944	This service paid on a diagnostic basis only. Treatment of the condition is denied.
945	Denied. This service is not payable in addition to an extensive or comprehensive office visit.
946	Denied. Emergency room calls for scheduled drugs for treatment of chronic pain are not covered.
947	Bill paid in summary detail. All future bills must show only one date of service per line space
948	Remainder of bill processed separately due to computer system limitations.
949	Payment for pharmacy made this time. Future bills must be submitted with code 99070 for pharmacy
950	Denied. When a worker is placed on pension the Department cannot pay schedule I, II, III, IV drugs
951	Time units must be billed as whole units. Please check your Fee Schedule and bill accordingly.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
952	Processing 80 per cent of the interim payment requested.
953	Denied. Service was prior to approved training plan start date.
954	Denied. There are no funds approved for this procedure code. Contact vocational counselor.
955	These services were paid by a hand warrant.
956	Reopening examination and application paid. Claim reopening is under consideration.
957	This is a deduction from the interim payment.
958	Adjusted. Mileage allowed based on number of miles by shortest direct route only.
959	Denied or adjusted. The per diem rate allowed includes lodging and meals for the day.
960	Denied. Side of body treated disagrees with the side of body accepted as injured in this claim.
961	Denied. This is not a Washington state industrial injury.
962	Adjusted. Remaining balance from this procedure fund paid. Notify the vocational counselor.
963	This deduction is taken for payment(s) made in error.
964	This payment is made for a deduction which was taken in error.
965	Denied. Claimant expired prior to date of this service.
966	This is a rebill, check for prior payment. If none received, resubmit.
967	No payment made because there were no charges listed on your billing.
968	Denied. The listed value for this service includes the professional component.
969	Denied. Provider tape billing fee is limited to one charge per claim in any 30 day period.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
970	Reopening denied.
971	Processed under correct claim no. for this date/nature of injury.Please note for future bills.
972	Waiting for signature certifying the delivery of services.
973	Denied. Excess invalid/missing detail on this bill. See billing instructions. Revise and rebill
974	Rebill dental professional fees on Labor & Industries Statement for Miscellaneous Service form.
975	Denied. The Department is not responsible for 'no show' appointments.
976	This fee is payment for medical records.
977	Please note the provider number.This is the number you must use when billing physician services
978	Please note the provider number. This is the number you must use when billing pharmacy services
979	Please note the provider number. You must use this number when billing for pain clinic services
980	Please note the claim number. It must be used when billing for this injury for this claimant.
981	Note the provider number and name. They must be on all billings sent to the Department.
982	The Department has no provision for payment of provider administrative costs.
983	Denied. Refill of this drug in less than 30 days must be justified by the attending physician.
984	Payment made to correct your account for the refund which you made to the Department in error.
985	Denied. This is a Social & Health Services bill sent to us in error.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
986	NDC number invalid or missing. If equipment, resubmit on Statement for Miscellaneous Services.
987	Denied. Service was not substantiated by attending physician and requires prior authorization.
988	The date of service is before the reopen date.
989	Denied. Claim number missing. Resubmit new bill with claim number.
990	Not paid. The provider must bill the Department and return your full payment directly to you.
991	Denied. Drug quantity is invalid. Resubmit using metric measuring only.
992	Bill paid.You must reimburse the insurance company the total amount they paid for this service.
993	Travel expense has been authorized only for the injured worker.
994	Do not include line items for services which you are crediting and no payment is due.
995	Labor and Industries is not responsible for payment while claimant is in DNR Forest Camp.
996	Payment to cancel balance of interim credit in this provider account. Credit transferred.
997	Refer to the accompanying explanation of benefits code listed for this service.
998	This transaction is a refund from this provider.
999	This adjustment is made per your request on a previously processed bill.
A01	APC discounting applied.
A02	APC packaged service.
A03	Qualifies for APC outlier.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
A04	Qualifies for outlier with discounting.
A05	APC packaged, considered in outlier amount.
A06	APC pass-through, considered in outlier amount.
A07	Denied. 7 <sup>th</sup> diagnosis invalid per code editor.
A08	Denied. 8 <sup>th</sup> diagnosis code invalid per code editor.
A09	Denied. 9 <sup>th</sup> diagnosis code invalid per code editor.
A10	Denied. Diagnosis and patient age are in conflict per the code editor.
A11	Denied. Diagnosis and patient gender are in conflict per code editor.
A13	Denied. Procedure is invalid per code editor.
A14	Denied. Procedure and patient age conflict per code editor.
A15	Denied. Procedure and patient gender conflict per code editor.
A16	Denied. Non-covered service per code editor.
A17	Denied. Condition code 21 (verification of denial) billed.
A18	Denied. Condition code 20 (submitted for review) billed.
A19	Denied. Defined as "questionable covered service" by code editor.
A20	Denied. Per code editor, code indicates site of srvc not in OPPS (Outpt Prosptv Pmt System).
A21	Denied. Per code editor, service units outside of range allowed for procedure.
A22	Denied. Per code editor, multiple bilateral procedures were billed without modifier -50.
A23	Denied. Per code editor, specification of bilateral procedure is inappropriate.
A24	Denied. Even w/modifier, code editor won't allow this mutually exclusive or component procedure.

## Dept. of Labor & Industries Explanation of Benefits

EOB	DESCRIPTION
A25	Denied. Per code editor, med visit without mod -25 not allowed with type "T" or "S" procedure.
A27	Denied. Per code editor, terminated bilateral procedure can't have more than 1 unit.
A28	Denied. Per code editor, an inconsistency exists between implantation procedure and device.
A29	Denied. CCI edit would allow this proper modifier. See <a href="http://www.hcfa.gov/medlearn/refguide.htm">www.hcfa.gov/medlearn/refguide.htm</a>
A30	Denied. Per code editor, multiple medical visits billed for same day without condition code G0.
A31	Denied. Per code editor, blood product for transfusion or blood product exchange not specific.
A32	Denied. Per code editor, observation revenue code billed with non-observation HCPCS code.
A33	Denied. Per code editor, service is not separately payable.
A34	Denied. Per code editor, modifier is invalid.
A35	Denied. Per code editor, revenue center requires HCPCS code.
A36	Denied. Per code editor, revenue code is invalid.
A52	Payment made at value of 1 unit. For units consideration, submit adjustment, justifying them.
A82	Denied. Non-case rate APC not allowed for the treatment of industrial injuries.
A86	Denied. This APC ID is not allowed for treatment of industrial injuries.
A91	Denied. Principal diagnosis code invalid per code editor.
A92	Denied. 2 <sup>nd</sup> diagnosis code invalid per code editor.
A93	Denied. 3 <sup>rd</sup> diagnosis code invalid per code editor.

## Dept. of Labor & Industries Explanation of Benefits

<b>EOB</b>	<b>DESCRIPTION</b>
A94	Denied. 4 <sup>th</sup> diagnosis code invalid per code editor.
A95	Denied. 5 <sup>th</sup> diagnosis code invalid per code editor.
A96	Denied. 6 <sup>th</sup> diagnosis code invalid per code editor.
A97	Denied. Dept. accepts only hospital types of bill 131 through 134 on HCFA-1450 (UB92).
B01	Denied. Proc code specific to your state. Refer to WA State fee schedule for appropriate code.
R01	Denied. Provider letter mailed separately to explain this denial.
R02	Denied. Injured worker letter mailed separately to explain this denial.
R03	Denied. Prescription co-pay letter mailed separately to explain this denial.
R04	Denied. Health care co-pay letter mailed separately to explain this denial.
R05	Denied. Pharmacy letter mailed separately to explain this denial.

## **Dept. of Labor & Industries Explanation of Benefits**

System Generated EOB's

<b>T01</b>	<b>Benefit</b>
<b>T02</b>	<b>Employee Wages</b>
<b>T03</b>	<b>Employer FICA (Federal Insurance Contribution) Social Security</b>
<b>T04</b>	<b>Employer FICA (Federal Insurance Contribution) Medicare</b>
<b>T05</b>	<b>FUTA (Federal Unemployment)</b>
<b>T08</b>	<b>Employee FICA (Federal Insurance Contribution) Social Security</b>
<b>T09</b>	<b>Employee FICA (Federal Insurance Contribution) Medicare</b>
<b>T12</b>	<b>Earned Income Credit</b>